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ABSTRACT

Infanticide in the United States today usually happens in the hospital. Occasionally, handicapped infants are killed by a direct act, but more often infanticide is accomplished by withholding something (for example, food, medication, surgery) that babies need to survive. The Rehabilitation Act of 1973, the Baby Doe regulations of May 1982, and the Child Abuse Amendment of 1984 are among the legislative measures that have attempted to protect handicapped infants' rights to medical treatment and general health care (including good nutrition). The decision whether to provide or withhold such services from handicapped infants has not been so clear-cut for health care practitioners and medical ethicists. Quality of life and the burdens on families and society posed by the responsibilities of raising and caring for handicapped individuals are issues that make suicide and mercy killing acceptable to many persons. Others believe that impaired infants are not human persons and hence not covered by legislation protecting individual rights. Doctors, nurses, and other health care professionals grapple with medical treatment decisions every day. They are pressured by a variety of factors including the catastrophic costs of care, and many health profesionals report being under increasing pressure to stop care when babies are irreversibly ill. Numerous case studies confirm that no religious, philosophical, or scientific consensus exists on the issue of infanticide, and for this reason, many hospitals have been spurred to form ethics panels or committees to address treatment dilemmas before they arise. (MN)

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INFANTICIDE: A CRITICAL ISSUE

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INFANTICIDE: A CRITICAL ISSUE

Norma J. Walters

Infanticide, as defined by Taber's Cyclopedic Medical Dictionary (1981), is "the killing of an infant; or one who takes the life of an infant" (p. 720). Manney and Blattner (1985) reported that some parents and their agents have been involved in infanticide for centuries. In the past, many parents have taken care of this gruesome ordeal themselves. Other peoples such as Eskimos living on the edges of survival have often disposed of babies with physical defects by exposing them to the elements. In other cultures, such as the Chinese, a strong bias in favor of male children often led to the killing of unwanted female babies to hide evidence of their sin.

The authors further revealed that infanticide in the United States today, usually happens in the hospital. Occasionally, handicapped infants are killed by a direct act, but more often by withholding something the babies need to survive. Sometimes a baby may not have a surgical procedure it needs to survive, an operation that would always be performed on a "normal" baby. Sometimes water and food may be withheld, sometimes large doses of drugs are used to sedate babies so that they will quietly starve without crying in hunger for food. In addition, infections may not be treated by withholding antibiotics, or the life-support system may be discontinued--because <u>someone</u> made the decision that the infant was struggling and the "quality of life" would not be adequate.

LEGISLATION AND INFANTICIDE

The offense of infanticide was first introduced into the Law of England and Wales in 1922 and further amended in 1938. Parker and Good (1981) reported the Infanticide Acts ameliorated the judicial process with regards to women who kill their babies. Both, a charge other than murder and a less severe disposal than would be normally warranted by the offense, was allowed, in cases where there was a mental imbalance attributable to the birth. The 1938 Act states that:

> Where a woman by any willful act or omission causes the death of her child under the age of twelve months, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child, then not withstanding that the circumstances were such that the offense would have amounted to murder, she shall be guilty . . . of infanticide and may . . . be dealt with and punished as if she had been guilty of the offense of manslaughter of the child (p. 239).

The Infanticide Act is unique in two respects: (a) it applies only to women, and (b) it provides a special defense for what was a capital offense, murder, in which the question of responsibility is bypassed. It must be shown that a mother suffered from a mental

imbalance attributable to the effect of giving birth or the consequent action for a verdict of infanticide to be returned. This verdict places the sentencing at the discretion of the judge.

However, provisions for attempted infanticide were omitted until a plea of guilty to attempted infanticide under the Criminal Attempts Act of 1981 was accepted by the Court. The Act states that "if, with intent to commit an offense . . . a person does not act which is more than merely preparatory to the commission of the offense, she is guilty of attempting to commit the offense.

In 1983, the United States Department of Health and Human Services (HHS) began to operate a 24-hour toll-free "hotline" set up by the regulations for reporting--anonymously--any case in which a handicapped newborn infant is denied care or nutrition. However, the court struck down the regulation.

Based on Section-504 of the Rehabilitation Act of 1973, which outlaws discrimination on the basis of handicap, the rule required hospitals to post notice of a hotline in all newborn nurseries and neonatal intensive care units (ICUs). Hospitals that failed to follow through, or denied the requisite care could lose medicare and medicaid funds (News: HHS, 1983). In revieving the regulatory history of the United States Department of Health, Education and Welfare (HEW), the predecessor of HHS, had adopted the position that 504 did not give it authority to regulate regarding patients' rights "to receive or refuse treatment." Rather, HEWs authority was to make services "accessible" or available to the handicapped,

so as to provide them with "an equal opportunity to receive benefits." In May 1977, (cited in Annas, 1984), HEW explained the difference:

> A burn center need not provide other types of medical treatment to handicapped persons unless it provides such medical services to non-handicapped persons. It could not, however, refuse to treat the burns of a deaf person because of his or her deafness (p. 728).

In fact, it was not until the May 1982 letter to hospitals that HHS ever suggested that 504 might reach to actual medical treatment decisions (Annas, 1984, 618-620). After reviewing the Baby Doe regulations, the court found that "the regulatory history of 504 was inclusive", of the enabling statute was "flatly at odds with the position originally taken by HEW," leaving the court to interpret the statute based on its language and legislative history. Cited in Annas (1984), Section 504 stated:

> No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in or be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance (p. 728).

The court concluded, therefore, that the Rehabilitation Act did not give HHS any authority to interfere with "treatment

decisions involving defective newborn infants. A big question remained, "what should the role of the government be in treatment decisions for handicapped newborns?" Incidently, about this time, HR 1904, the Child Abuse Amendment of 1984 provided, that all state child protective service agencies, health care facilities, and health professionals develop procedures to insure that medically indicated treatment, nutrition (including fluid maintenance), general care, and social services as appropriate, be provided to infants at risk with life-threatening congenital impairments. Also, the Act included specific requirements for HHS to: (a) publish guidelines to encourage and assist health care providers desiring to establish local health care mechanisms for the review of care provided to infants at risk with life-threatening congenital impairments; (b) develop a directory of available medical and community resources; and (c) determine the most effective means of supporting the medical treatment of such infants financially. This direction only empowered the federal government to support state abuse efforts with financial and technical information and not direct involvement in individual cases.

In addition, to legislation relating to infants at risk with life-threatening congenital impairments is fetal abuse; the 1973 Supreme Court decision--Roe vs. Wade. This provision which legalized abortion, did more than give women the right to choose. It stipulated an implied two-pronged obligation. If a woman chose not to have an abortion, she would be obligated to provide the best

possible environment for her child, in and out of the womb. If on the other hand, a woman refused to discontinue activities or habits proven dangerous to a fetus, it would be her obligation to abort the unborn child (Benson, 1984).

Before the Supreme Court legalized abortion throughout the country in 1973, only a handful of state medicaid programs covered abortion, unless the procedure was necessary to save the woman's life (Robinson, Pakter & Svigir, 1974). However, there were no restrictions on the federal medicaid payments for abortion until 1976, when Congress passed the Hyde Amendment, limiting reimbursements to abortions needed to save the woman's life. Except for the first seven months of 1980 (when medicaid funding resumed) federal payments for abortion have been severely restricted. The Hyde Amendment added new versions in 1976 and 1979 to permit funding when a pregnancy resulted from rape or incest, if the crime was promptly reported to law enforcement officials, or if two physicians confirmed that the woman would suffer severe and long-lasting physical health damage if her pregnancy was continued. The physical health damage criterion was dropped in 1980. Since June 1981, abortions have been reimbursable under medicaid only if the woman's life would be endangered by carrying the pregnancy to term.

Despite legislation, ethics committees, thoughts of health care professionals, right-to-life groups, or other individuals the concern continues and the question regarding infanticide may not

always be answered to satisfaction for everyone. Whether it is neonaticide (parents killing an infant) or active euthanasia (hastening the infant's death), the question remains, "Is infanticide right or wrong?"

Ethical Decision Making and Dilemmas

Ethical thinking of the medical profession regarding the quality of life, is being dominated by a new scheme of ethics. This "new medical ethic" was described in California medicine in 1970. The anonymous editorialist thought that the medical profession was caught between two ethics: (a) the old ethic, nurtured by the Judeo-Christian moral tradition, placed great emphasis on the intrinsic worth and equal value of every human life regardless of its stage or condition; and (b) opposing it is a quality of life ethic that would make it necessary and acceptable to place relative rather that absolute values on such things as human lives.

In the past, babies have been killed for all the reasons cited by the anonymous author: (a) because others think a handicapped infant's life is not worth living; (b) because the burdens of raising handicapped children will interfere with the personal well-being of their parents and siblings; and (c) because disabled people are unproductive and expensive social burdens.

The theologian, Joseph Fletcher (1972) is often quoted by physicians who advocate infanticide-on-demand. Fletcher believes that infanticide is acceptable because human beings have a moral

obligation to increase human well-being wherever possible and that questions in one of his essays on human life that, "all rights are imperfect and can be set aside if human need requires it" (p. 3).

Suicide and mercy killing are acceptable in this scheme, as is infanticide. Such acts are not regrettable necessities or grim compromises with one's conscience, but positive human goods (cited in Manney & Blattner, 1985). Fletcher also writes, "that in some situations a morally good end can justify a relatively "bad means" (1980, p. 301).

Treatment or Non-treatment of Handicapped Infants

Ethicist relate other reasons for infanticide. Some simply think that impaired babies are not human persons. One philosopher, Michael Tooley (1972) of Stanford University, reported that it is unfortunate that most people use the terms person and human being interchangeably. Tooley says, persons have rights (including the right to life) however, not every human being can properly be regarded as a person. His rule: "An organism possesses a serious right to life only if it possesses the concept of experiences and other mental states, and believes that if is itself such a continuing entity." With this philosophy, Tooley would allow infanticide up to a week after birth.

If Tooley doubts the personhood of the handicapped baby, then Joseph Fletcher (1972) doubts even the child's humanity. Fletcher has confused the modernist with about 15 criterion to make the critical judgement about whether someone is human. Some of these

include: (a) a minimal intelligence; (b) a sense of future; (c) a sense of the past; (d) a capacity to relate to others; and (e) a balance between rationality and feeling.

He is very specific about some criteria and very vague about others. For example, a human being with an I. Q. of 40 is considered only questionably a person and if the I. Q. is below 20, he is definitely not a person.

Other ethicists more subtle than Tooley and Fletcher have exercised great influence on medical thinking about these questions and many of their answers have been equally unsatisfactory. A common reaction to opinions by Tooley and Fletcher would be to dismiss them as grotesque musings by eccentric academics. However, they are an important part of the puzzle of infanticide and its growing acceptance.

Doctors look to specialists in bioethics for guidance in their treatment of newborns who are handicapped. So do policy makers, parents, and hospital administrators. In the past, theologians and philosophers have been involved with the federal government commission that sanctioned experimentation on unborn babies scheduled for abortion, and on the presidential commission in 1983 that decided that stiffer penalties were not necessary to stop infanticide.

Years ago, McCormick (1974), writing in the Journal of the American Medical Association, one of the most influential medical journals in America, gave a relational principle for the

handicapped newborns. A life that is "painful, poverty-stricken and deprived, away from home and friends, oppressive," may be a life of which it could be said that "human relationships--which are the very possibility of growth in love of God and neighbor--would be so threatened, strained or submerged that they would no longer function as the heart meaning of the individual's life as they should." The Christian can say, in these cases, that life has achieved its potential and the individual can be allowed to die.

McCormick hoped that these guidelines would assist in making decisions about sustaining the lives of grossly deformed and deprived infants. However, his guidelines raised many questions, such as: (a) How can healthy adults with no experience of disabilities imagine the quality and value of relationships a handicapped baby might have in future years? and (b) What does grossly deformed and deprived mean?

The relationship principle does not compel anyone to agree with McCormick. However, Horan, (1980) reports that, "There is no way that the relational principle can be less than a death warrant for some retardates except in the hands of McCormick himself." The principle falls apart as some one begins to apply it to specific cases. However, in 1983 McCormick co-authored with Paris, "Saving Defective Infants: Options for Life or Death" and presented more cautions since infanticide had become more common. These included: (a) babies should not die because their families cannot cope with them; (b) retarded babies should not be left to starve

because they are retarded; (c) non-treatment decisions are not private matters as doctors claim; (d) the courts can properly intervene when decision-makers behave irresponsibly.

Life and death decisions creates an ethical dilemma for doctors, nurses, parents and other health care professionals. "To treat or not to treat" infants is a judgement made by someone. Despite the benefits that respirators and other life-saving equipment, doctors don't know if aggressive health care will help infants get better or merely extend their existence. Infants with an unclear prognosis can put parents and health professionals in a tough position. Physicians don't want to prolong the suffering of an incurably ill newborn, yet they are dedicated to helping babies survive (Fackelmann, 1986).

In addition to the handicapped infant, there is the issue of abortion or the unwanted child, which has raised questions of rights and moral behaviors. These issues have been in controversy for several years.

Abortion or the Unwanted Child

Dr. James Prescott (1976) from the National Institute of Child Health and Human Development, pointed out that the questions of abortion and moral behavior are unlikely to be resolved by religious convictions, or theological doctrine, since such convictions and doctrine vary considerably among free people and are, at best, arbitrary in their formulation and implementation. The anti-abortion movement believes that even in the embryonic

stage of development, the fetus is human life and that any deliberate termination of embryonic or fetal life constitutes an "unjustified termination of human life"- that is, homicide. Conversely, proponents of abortion deny, particularly during the embryonic stage of development that a fetus is human life. Therefore, they believe that the termination of fetal life does not constitute homicide.

In addition, proponents of abortion justify termination of a fetal life by asserting: (a) that the woman has the ultimate right to control her own body; (b) that no individual or group of individuals has any right to force a woman to carry a pregnancy that she does not want; (c) that parents have the moral responsibility and constitutional obligation to bring into this world only children who are wanted, loved, and provided for so that they can realize their human potential; and (d) that children have certain basic human and constitutional rights, which include the right to have loving, caring parents, sound health, protection from harm, and a social and physical environment that permits healthy human development and assurance of "life, liberty, and the pursuit of happiness."

Prescott also reported that conflicts of rights of the fetus, the rights of the woman, the rights of the child, the rights of adults to unlimited reproduction, and the rights of society, need very careful consideration in evaluating the morality of abortion.

These rights bring many questions which have been unanswered. Some may include:

1. Do adults who are incapable of responsible behavior (mentally retarded, for example) have the right to bring children into this world who will be neglected and abused and who will become infant-and child- mortality statistics?

2. Is the right to parentage absolute?

3. Is it not more moral and humane to prevent a life than to permit a life that may experience deprivation, suffering, and perhaps a brutal early death, which many of our child abuse and infant-and child-mortality statistics reflect?

4. Is mere physical existence our highest goal and greatest moral burden or is the quality of human life our highest goal and greatest moral burden?

5. What are the moral and social criteria for justifying the sacrifice of human life?

A number of cultures have practiced the killing of female infants because they were valued less than male infants. Recent reports from the People's Republic of China have also suggested an apparent growth in female infanticide, and the use of amniocentesis for sexing. One clinic reported that amniocentesis and antenatal sex determination had come to their rescue and could help in keeping some check over the accelerating population as well as give relief to the couple requiring a male child (Jeffrey, R., Jeffery, P. & Lyon, 1984). These patterns could have a direct link between

more female infanticide and female neglect leading to higher infant and child mortality rates and female foeticide.

Infant Euthanasia

The killing/letting die controversy must qualify as one of the hoarier problems in bioethics. There are two types of cases where some are inclined to advocate infant euthanasia:

1. The first type is evidence that the infant will die relatively soon anyway, no matter what is done. However, this death can be prolonged if certain treatment is initiated. This treatment may be extraordinary, such as the use of a respirator or the performance of routine surgery. In either case if nothing is done, the child will die immediately; or if treatment is initiated, it is believed that they will live longer but will die in a relatively short period of time.

2. In the second type of case, the infant can be saved but at great expense. If nothing is done the infant will probably die soon. However, if treatment is initiated, the infant will be able to live more or less indefinitely. The expense incurred is the great burden that must be born if the infant is saved. Financial and emotional burdens will fall on the parents and may also burden the infant.

Weir (cited in Murray, 1985) concludes that there are three necessary and jointly sufficient conditions for active infant euthanasia: (a) that it be responsibly determined that "life-prolonging treatment is not in the best interests of the child; (b)

that the child otherwise endure prolonged suffering; and (c) that the killing be carried out quickly and painlessly.

There are circumstances where society does condone the taking of life, in war, or in defense against an unprovoked and life-threatening attacker. Even in war, we distinguish among those who can be killed, combatants-and those-noncombatants, including civilians and prisoners of war, who cannot. However, some may not agree with Weir's conclusion, probably because his conception of the issue is too narrow.

Weighing the Cost

Doctors, nurses and other health care professionals are constantly grappling with medical treatment decisions every day. They are pressured by a variety of factors, including the castastrophic costs of care. Health care costs now consume in excess of 10% of the gross national product, up from 7.2% in 1970. Physicians must balance the benefits of using a procedure with the expense in today's hospitals. Certain patients may never receive potentially life-saving care because they are judged to be unlikely to recover. There are others who may not receive expensive treatments because their families don't have insurance or money.

Physicians say treatment decisions are going to be even more difficult as technical breakthroughs allow them to save very tiny babies. Even though the publics attention has been focused on the multiply-handicapped Down's Syndrome babies, low birth weight infants pose the greater problem for health professionals.

Surgery, physicians say, can be predicted, however, tiny newborns often have multiple problems and its difficult to identify the infants who will prosper given the appropriate medical care, as reported by Arthur Kohrman, MD, chairman of the pediatric ethics committee at the University of Chicago.

Health professionals say they are under increasing pressure to stop care when babies are irreversibly ill. Newborns with lov birth weight can have hospital bills of $1,000 a day in an intensive care unit, with only a portion paid by Medicaid as federal and state health programs do not pay the entire amount. The result is uncompensated care for a hospital. Some financially squeezed hospitals may be forced to draft no-treatment-guidelines for hopelessly ill newborns as they become less able to absorb the unpaid medical bills. Is it possible that some may decide to end care without parental consent when babies can no longer be helped?

Maternity Care: Patients and Cost. Researchers at the National Bureau of Economic Research reported that Medicaid-subsidized deliveries each year is comprised of nearly 542,000 lov income vomen. Federal and state governments together spent almost $1.2 billion for Medicaid maternity care in 1985. The average per patient, weighted for the number of births in each state, vas $2,200. The largest component of maternity care payments is hospitalization. Payments ranged from $780 per delivery in Louisiana to $2,600 in Ohio (Kenny, Torres, Ditters & Macies, 1986).

Neonatal Intensive Care. The National Institute of Medicine (1985) revealed that Medicaid payments for neonatal intensive care expenditures ranged from $2,000 in Oregon to $29,400 in Nevada, with a mean of $11,800 for 1985. The authors concluded that reducing the need for neonatal intensive care would dramatically lower Medicaid expenditures for the first year of life. Increased use of prenatal care could also be expected to reduce demand for neonatal intensive care by improving pregnancy outcome.

Cost Benefit Analysis for Low Birth Weight Infants. A recent study cited in Death by Design of Handicapped Newborns: The Family's Role & Response (Rue, 1985), an attempt was made to simplify and reduce decision making regarding "at risk" infants to a cost-benefit analysis, which presumably can be applied to any infant decision-making treatment. Based upon birth weight and economic benefit, infants, of 900 grams or greater are approvingly selected for life. Data are shown in Table 1.

Curiously, 32% of infants weighing 500-1,000 g, survived with 72% being normal or minimally handicapped in this study. From low birth weight infants to those born with mental retardation, cerebral palsy, spina bifida, blindness, and loss of limb, the decision is brutally clear: death by design for economic benefit. The author noted that it is possible that the elimination of other

Table 1.

Cost Benefit Analysis for Low Birth Weight Infants

Birth Weight (g)	Total Cost/ Survivor*	Average Lifetime Earnings	Expense/ Income Differential	Optimum Decision Outcome
500-599	---	0	0	death
600-699	$362,992	0	0	death
700-799	$116,221	$55,138	-$61,083	death
800-899	$101,356	$49,887	-$51,469	death
900-999	$ 40,647	$77,031	+$36,384	life

*Sum of projected hospital, physician, long term care costs.

types of "dependents" might also be considered such as: students, unemployed, grandparents, and uneducated minorities, because of the heavy burden on families and their increasing demands on our municipal services and increasing taxes as well. Margaret Sanger, (cited in Rue) founder of Planned Parenthood, prophesied years ago in The Pivot of Civilization (1922):

> . . . the most urgent problem today is how to limit and discourage the over fertility of the mentally and

physically defective. Possibly drastic and Spartan measure may be forced upon American society . . . (p.3)

Ethics Committees/Panels

Many hospitals have been spurred to form ethics panels or committees due to an increasingly complex medical world. These groups of doctors, nurses, lawyers, and members of community advise parents with a struggling decision. Some evidence suggests that hospital administrators are forming ethics panels or committees before a problem case arises. A 1985 survey by the American Academy of Pediatrics of hospitals with neonatal care units found that nearly 66% had an ethics committee (Fackelmann, 1986).

The extensive debates in today's society clearly indicate that no religious, philosophical, or scientific consensus exists concerning the question of whether fetal life is human life, or which handicapped infant should survive. These situations create many dilemmas for the health care professionals.

Many times the decisions are just too tough to be handled without guidance according to medical ethics experts. During early 1986, physicians at Presbyterian-University Hospital in Pittsburgh, Pennsylvania wrote an article in Critical Care Medicine that urged hospitals to adopt policies to help doctors and nurses who must work with seriously ill newborns or adults. The authors reported that health care workers can be placed in a legal limbo, even though 80% of state legislatures have passed a natural death act.

The guidelines the physicians designed and included in their report was intended to assist physicians make these tough judgment calls.

Case Reports, Pros-Cons, and Dilemmas

There are certain cases in the literature relating to treatment-non-treatment of infants and abortions which provide examples of ethical dilemmas. Some of these are listed below:

Case 1

The original Baby Doe case occurred in 1982, a baby born with Down's Syndrome and other anomalies that required surgery. Parents chose not to permit surgery and requested that the infant not be provided nourishment or any life support treatment; the infant was allowed to die at the parent's request. This case has prompted an attempt to secure assurance that lives of handicapped children would be protected even against wishes of family. Guidelines were provided to all hospitals (5,800) that receive Federal funding.

Even though the parents refused the surgery and the hospital asked the court for guidance and the baby died six days after the appeal, Carolyn Murphy says the American Nurses Association (ANA) would agree that it's a dangerous thing to make rash decisions about the quality of life possible for some handicapped infants. On the other hand, some of these children are born with multiple anomalies and keeping them alive may mean subjecting them to prolonged suffering (News: HHS Stands By, 1983).

Case 2

Baby Jane Doe born in 1983, first child of young parents, married one year, suffered from spina bifida, hydrocephaly, and microcephaly. Physicians recommended immediate surgery to reduce fluid in her skull and close her meningomyelocele which could increase life expectancy from a few weeks to 20 years. However, she would likely be severely retarded, epileptic, paralyzed, bedridden, and subject to constant urinary tract infections. Parents refused to consent to surgery after lengthy consultations, opting for antibiotics and bandages for prevention of infection. Physicians disagreed.

A Vermont right-to-life lawyer filed suit to obtain an order for surgery to be performed and Melvyn Tanenbaum, the trial judge appointed Attorney William E. Weber to represent the child. Weber agreed with parents then reversed his decision at the hearing because medical records disagreed with the prognosis given by physicians to parents and Tanenbaum ruled the infant was in need of immediate surgery. Parents appealed, Appelate Division reversed Judge Tanenbaum, ruling parent's decision was consistent with best interests of child. The court of appeals also ruled Attorney Washburn had no disclosed relationship with the child, her parents, her family or those treating her and that allegations of child abuse or neglect must be made to the state Department of Social Services and dismissed suit.

The United States Department of Health and Human Services (HHS) received a hotline complaint and referred it to the New York Child Protection Services which concluded there was no cause for state intervention. Surgeon General C. Everett Koop concluded that he could not determine the basis for denial of treatment. Under Section 504, HHS brought suit in U. S. District Court to get child's records. The District Court concluded that the hospital failed to perform the surgery not because of the child's handicap, but because of parental refusal. Therefore, the hospital was not in violation. HHS appealed; the Court of Appeals concluded that Baby Jane Doe fit the definition of a handicapped individual, but determined she was not otherwise qualified, because the phrase referred to handicapped individuals who could not benefit from the services in spite of their handicap itself is the subject of service (Annas, 1984, p. 727-729).

Case 3

Siamese twins, joined together at the waist and sharing the lower stomach and bowels were gasping for air at birth. Anesthesiologist said, "Ventilate;" the other doctor called to assist with the difficult birth said, "Don't resuscitate, lets' cover the babies." A nurse turned off the oxygen and went to the nurses lounge and "sat down in shock," as reported in the New York Times, July 2, 1981. The twins survived the birth and the doctor allegedly gave orders not to feed them in accordance with a request

from the parents. No witness linked the parents with any orders to withhold food or medical care, however, the state presented a medical chart with the entry, "Do not feed infants, in accordance with parents wishes." The judge, John P. Meyer, ruled that as hearsay and excluded it from testimony.

At the custody hearing, the judge upheld the state's contention that the twins had been indeed, denied food, water, and medical care. However, he did not rule on "who was responsible for the abuse". That was the central issue remaining in the criminal charge against the parents and physicians.

The state was awarded custody of the twins and the judge said that the right to live is given even to newborn Siamese twins with severe anomalies. He also asked: "Has society retrogressed to the stage where we mortals can say to a newborn abnormal child, you have no right to live with a little help from us?" "I hope not and think not, although the evidence in this case goes on to contradict me" (Horan, 1982).

In Horan's article, "Infanticide: When Doctor's Orders Read Murder," he reported that charges of attempted murder filed against these parents and attending physicians of the newborn Siamese twins at Lakeview Medical Center in Danville, Illinois, brought attention to the public of a little known fact: Infanticide by starvation and neglect, is becoming more common in intensive-care nurseries-at the request of parents and by the order of physicians. He also

reported that nurses are at risk of homicide charges, civil suits and loss of license and reputation in the community while caught in the middle of the criminal activity.

Kenneth Vaux, a professor of medical ethics at the University of Illinois, College of Medicine in Chicago, participated in a discussion of the Danville case at Hastings Institute. He reported that "most" of his colleagues in medicine, nursing, philosophy, theology, and ethics felt that the initial decision of doctors and family not to begin life support, even feeding and a sip of water, was justifiable in light of the jeopardy the birth presented to the family and the drawn out suffering implied for the infants. One nurse reported the Danville twins as having three legs, one with a half foot with seven toes, two legs sticking out of one side and one on the other (Horan, 1982, p. 82).

Case 4

Dr. Raymond S. Duff, a pediatrician and professor at the Yale University's School of Medicine contradicts Judge Meyer in Case 3. Dr. Duff and his co-author, A. G. M. Campbell, wrote in a paper in the new England Journal of Medicine that they had studied 299 deaths in the nursery over a 2.5 year period. Forty-three (14%) deaths in the special-care nursery at Yale New Haven Hospital died after parents and physicians jointly agreed to discontinue treatment because of multiple anomalies, meningomyelocele, cardiopulmonary crippling or other central nervous system defects.

The other 256 who received the best treatment modern medicine and nursing could provide lived little, if any longer, than those who received no special treatment. For each of the 43 babies for whom no further treatment was given, the physicians and parents made a decision that the prognosis was very poor or hopeless for "meaningful life."

Doctors Duff and Campbell wrote that the awesome finality of these decisions, combined with a potential for error in prognosis, made choice agonizing for families and health professionals (Creighton, 1984).

Case 5

A six weeks old male infant with shiny black hair had a respiratory arrest. Physicians ruled out botulism, obstructive airway problems, bacterial and viral infections, and muscular diseases. The infant improved slightly for about a month, then had to be returned to the respirator and a mesogastric tube. The family and staff were frustrated because he was ventilator dependent and deteriorating, even though he would squeeze a finger when put in his hand. His family did not want him to suffer and opted against a tracheostomy if it was just going to prolong his suffering. Finally, the case went to the ethics committee. The director of the intensive care unit was going to ask permission to withdraw life support.

The lack of a definite diagnosis was the only factor against withdrawing life-support. He was believed to have a degenerative neuromuscular disease, could not be weaned from the ventilator, was hypotonic and probably blind and deaf as well. He was not brain dead but he did have brain damage from his unknown, untreatable disease. He could also move slightly and coughed and gaged when suctioned. The committee composed of lawyers, social workers, clergy, physicians and nurses voted unanimously to discontinue life support. The physicians had examined him only briefly and the lawyers and social workers had never seen him. One woman on the committee kept asking questions and did not understand that technology could keep the dead alive.

This was a dilemma, especially having the woman on the committee and others like her who seemed not to understand. Even though the lay person's opinion is needed, how could someone who has never even seen a ventilator possibly understand how it works? How could someone who had never seen the baby, make an intelligent decision about whether he was fit to live or die (Edwards, 1986)?

Case 6

Consequences of denied abortions were studied by Forssman and Thuve who examined the development of children from birth to age 21. The sample included 121 children who were compared with a control group of children who's mothers had not applied for abortion. In the unwanted group, 17% were born out of wedlock, vs

only 8% of control group. The statistically significant differences are summarized as follows:

1. Sixty percent of unwanted children had an insecure childhood vs 28% of control group (unsatisfactory home conditions, moving from home to home, parents divorced or deceased by the time the child was age 15, and born out of wedlock and never legitimized).

2. Twenty-eight percent of unwanted children had recieved some form of psychiatric care, compared to 15% of control group.

3. Eighteen percent of unwanted children were registered with child-welfare boards for delinquency, compared to 8% of the controlled children.

4. Fourteen percent of unwanted children received some form of welfare between the ages of 16 and 21 vs 2.5% of control group.

5. Fourteen percent of unwanted children had some form of higher education, compared to 33% of control group.

6. Sixty-eight percent of control children showed none of the social disabilities mentioned above vs only 48% of unwanted children.

In brief, unwanted children were more than twice likely to suffer social, emotional and educational disadvantages as wanted children. In addition, unwanted children appear to present certain costs to society such as increased delinquency, a higher number of welfare recipients, a more poorly educated citizenry, and a greater

number of psychiatric problems. These results strongly support the right of the woman to be pregnant by choice and to be a mother by choice as essential prereqiusites for a humane and compassionate society (Prescott, 1976).

Case 7

A team of doctors and other clinicians, using a quality of life formula, recommended that 24 out of 69 babies born with spina bifida between 1977 and 1982 not be aggressivley treated. The 24 untreated babies died at an average of 37 days. Of those who were recommended for aggressive treatment, all lived except one killed in a car accident. Of those not recommended for treatment, six of eight babies whose parents went ahead with treatment, lived. The treatment recommendations were based in part on the child's expected "quality of life". This was formulated by multiplying the childs natural environment with the sum of the financial and emotional contributions expected from the child's home and society:

$$QL = NE \times (H + S)$$

The formula was created by Dr. Anthony Shav. The results of this study has caused considerable controversy (Creighton, 1984).

Summary

Infanticide or the killing of an infant has occured throughout the nation for centuries. Usually, infanticide is confined to handicapped infants with several anomalies or through abortion of unwanted children.

The first offense of infanticide was introduced into the Law of England and Wales in 1922 and amended in 1938. The act only applied to women and resulted in probably a lesser penalty in cases where there was a mental imbalance attributable to birth with the verdict and sentencing by the judge. However, provisions for attempted infanticide were not approved until the Criminal Attempts Acts of 1981. In addition, the Rehabilitation Act of 1973 prohibited discrimination of care for the handicapped.

Later, the Child Abuse Amendments of 1984 provided that all state child service agencies, health care facilities, and health care professionals develop procedures to insure that medically indicated treatment, nutrition, general care, and social services as appropriate be provided to infants at risk with life threatening congenital impairments. The Act also included special requirements for HHS to: (a) publish guidelines for review of care provided to infants at risk, (b) develop a resource directory, and (c) determine the effective means for supporting medical needs of at risk infants, financially. Also the Supreme Court decision--Roe vs Wade, in 1973 legalized abortion and gave the woman a right to choose with the Hyde Amendment in 1979 permitting funding for abortion for rape or incest.

Despite legislation, ethics committees to assist in decision making for infants at risk, thoughts of health care professionals, right-to-life groups or other individuals, the concerns continue

regarding infanticide: Whether it is neonaticide (parents killing an infant) or active euthanasia (hastening the infant's death), the question remains, "Is infanticide right or wrong?"

The government has the right to assure services and resources are available and enforce the laws. The parents have different viewpoints on infanticide. Some believe they do have the right to make life or death decisions if there are multiple, anomalies, stress on family, finanical burdens and if the infant is only existing and cannot get better. Others, cannot make decisions and request health care professionals to assist them.

Proponents of abortion think: (a) termination of a fetus is not homocide; (b) that a woman has the right to control her body; (c) no group or individual should force a woman to carry an unwanted pregnancy; and (d) that children have basic and constitutional rights of having parents who live and care for them and can provide a safe environment. Anti-abortionists believe that even in the embryonic stage, the fetus is human life and deliberate unjustified termination is homicide, especially abortion for choosing sex.

Some believe that: (a) babies have a right to life and should not die because families cannot cope with them. Others think babies would prefer to die, especially if life support measures such as ventilators are required or if pain and suffering continues.

Ethicists relate many reasons for infanticide such as all human beings are not persons unless the infant has minimal intelligence, a sense of future and past, can relate to others, has a balance between rationality and feeling, and has an I. Q. of at least 40. Others use formulas to establish quality of life.

Society, also has a right to know the cost-benefit ratio of patients receiving medicaid for maternity care and neonatal intensive care. The increasing demand on municipal services and taxes are also of grave concern.

Case reports of infanticide are found in the literature such as multiple-handicapped, Down's Syndrome babies, low birthweight infants which relate to withholding of surgery, food or other medical treatment. Some health care professionals appear to be involved in the decision making process for life or death and some are requesting Ethics Committees.

Physicians, nurses and other health care professionals say that in the future it is going to be even more difficult to make the decisions on the life and death issue, with all the new technical breakthroughs, because decisions may affect health care personnel and they may suffer loss of employment and licensure.

Life and death decisions create an ethical dilemma for health care professionals--'to treat or not to treat'--infants is a judgement to be made by <u>someone</u>. Unclear prognosis can affect everyone involved. Physicians and other health care workers do not

want to prolong suffering of an incurable ill infant; yet, they are dedicated to helping babies survive. However, the question on 'Infanticide' still remains a critical issue, 'who pulls the plug?'

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